United States General Accounting Office

GAO

Testimony

Before the Committee on the Judiciary
United States Senate

For Release on Delivery
Expected at
2:00 p.m.
Tuesday
July 28, 1992

HEALTH INSURANCE

More Resources Needed to Combat Fraud and Abuse

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HEALTH INSURANCE: MORE RESOURCES NEEDED TO COMBAT FRAUD AND ABUSE

The size of the health care sector and sheer volume of money involved make it an attractive target for fraud and abuse. Health insurance experts estimate that fraud and abuse contribute to some 10 percent of the $700-plus billion currently spent on health care. Relative to the magnitude of the problem, GAO believes that resources devoted to combatting health insurance fraud are small.

Profiteers are able to stay ahead of those who pay claims, in part, because of the obstacles to preventing and pursuing dishonest practices, which include overcharging for services provided, charging for services not rendered, accepting bribes or kickbacks for referring patients, and rendering inappropriate or unnecessary services. Insurers have difficulty discerning wrongful acts amidst the multiple activities that take place at the time of processing claims. Collaboration on fraud case development among industry members is limited, however, due to concerns over violating privacy and antitrust laws.

Once detected, moreover, fraud is expensive and slow to pursue both criminally and civilly; even convictions often do not result in the recovery of losses. In particular, limited prosecutorial and judicial resources can constrain state and federal prosecutors from pursuing health care cases involving relatively small dollar amounts. In several jurisdictions, for example, federal prosecutors said they generally accept only criminal health care cases that are clear-cut and involve $100,000 or more, because caseloads for such crimes as savings and loan fraud and drug-trafficking consume substantial prosecutorial resources.

Two federal agencies significantly involved in pursuing health care fraud are the Department of Justice and the Office of the Inspector General in the Department of Health and Human Services (HHS). Both cite limited resources as a problem. Although the number of Inspector General investigators has remained virtually unchanged over the last 5 years, the Inspector General's statutory responsibilities and the size and complexity of the federal programs that the Inspector General investigates have increased significantly. Without adequate resources, however, effective investigation and pursuit of health care fraud is not possible. Thus, an essential health care system goal must be to improve insurers' access to legal and punitive remedies to fraud and abuse.

Added resources alone, however, will not succeed in overcoming fraud and abuse in the health insurance industry. Structural issues such as limitations on information-sharing among insurers and incompatible data systems hamper efforts to detect the providers' aberrant billing patterns. Because of the complexity involved in remedying these problems, GAO asked the Congress to consider establishing a national commission to develop comprehensive solutions to health insurance fraud and abuse.

Dear Mr. Chairman:

I am pleased to be here today to discuss health insurance fraud and abuse and the need for greater investigative and prosecutorial resources to combat the problem. The starting point for this discussion can be found in our recently issued report on the vulnerability of payers to fraud and abuse.[1] In it we discuss the numerous obstacles to preventing and pursuing the dishonest practices of health care profiteers.

Our report cites an estimate made by health industry officials that fraud and abuse contribute to some 10 percent of U.S. health care's current $700-plus billion in costs. We would like to reiterate that although there is consensus among health experts on this estimate, the hidden nature of fraudulent and abusive practices is such that no one can be certain of their share of the nation's health care expenditures. Our work to date, however, suggests that the 10 percent figure is reasonable.

The size of the health care sector and sheer volume of money involved make it an attractive and relatively easy target for fraudulent and abusive providers. We believe that resources devoted to combatting fraud and abuse are small relative to the magnitude of the problem. It will be helpful to first discuss the nature of health insurance fraud and abuse, the resources available to combat it, and problems with prosecution.

HEALTH INSURANCE FRAUD AND ABUSE

Several problems in the health insurance system allow unscrupulous health care providers to cheat health insurance companies and programs out of billions of dollars annually. The problems do not fall into mutually exclusive categories, but in general they include the following:

-- Health insurers operate independently and are constrained by legal and administrative limitations from collaborating on efforts to confront fraudulent providers. Ultimately, even when fraudulent providers get caught by one insurer, they can continue billing other insurers.

-- Criminal prosecution and civil pursuit of fraud is expensive, slow, and has been shown to have little chance of recovering financial losses. Moreover, private insurers are largely without access to the administrative remedies of the public payers, such as the ability to exclude providers convicted of health care fraud from billing the public programs.

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[1]Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (GAO/HRD-92-69, May 7, 1992).

-- Insurance and law enforcement resources are not sufficient to detect and pursue health care fraud effectively.

The vulnerability of the health care system to fraud and the damage that it can cause is illustrated by a California scheme that has resulted in the loss of millions of dollars. The case is alleged to have involved over $1 billion in fraudulent billings from as many as 200 physicians and other providers. This scheme centered around getting people with health insurance covering fee-for-service providers to go to mobile labs, called "rolling labs," that did noninvasive tests, such as heart and blood-pressure measurements. Frequently, the labs and the referring physicians used phony diagnoses in submitting the insurance claims.

The outcome of this scheme so far is that the owners have been both sued and prosecuted successfully, yet virtually no monies have been recovered. Also, at least six similar schemes are known to be operating in southern California. Schemes of this nature highlight several serious problems facing public and private payers. First, large financial losses to the health care system can occur as a result of even a single scheme. Second, fraudulent providers can bill insurers with relative ease. And third, efforts to investigate, prosecute and recover losses from those involved in the schemes are time-consuming and costly.

Today I would like to focus on the problems of investigating and prosecuting health insurance fraud.

PROBLEMS INVESTIGATING AND PROSECUTING HEALTH INSURANCE FRAUD AND ABUSE

Insurers face significant legal hurdles and expense in investigating, prosecuting, and recovering losses from fraudulent or abusive providers. Investigative and prosecutorial resources and priorities vary by jurisdiction, often constraining state and federal prosecutors from pursuing health care cases involving relatively small dollar amounts. In several jurisdictions, for example, federal prosecutors told us that they generally accept only criminal health care cases that are clear-cut and involve $100,000 or more, because caseloads for such crimes as savings and loan fraud and drug-trafficking consume substantial prosecutorial resources. An official from a large insurance company with an active fraud detection program told us that only about 1 percent of all cases referred to federal prosecutors were accepted.

An irony of the criminal prosecution approach is that a single large fraud case can consume significant investigative and prosecutorial resources, leaving other cases unpursued. For example, in the case of the rolling labs scheme, California state investigators told us that similar schemes allegedly operating in the same geographic area are not likely to be investigated or prosecuted until the rolling labs case goes to trial.

The lack of investigative resources has constrained two federal agencies significantly involved in pursuing health care fraud--the Department of Justice and the Office of the Inspector General in the Department of Health and Human Services (HHS).

Department of Justice efforts to combat health insurance fraud have been adversely affected by resource constraints. Recognizing the need for additional resources to address health care fraud, the Federal Bureau of Investigation (FBI) announced in February 1992 that 50 agents were being reassigned from other areas to health care. This means that a total of 150 agents nationwide will be devoted to health care cases. At the same time, the Department of Justice assigned 10 new positions to enforce a health care fraud initiative and formed a health care fraud unit within its criminal division.

Similarly, the HHS Inspector General cites resource limitations as a major impediment to investigating and pursuing many types of fraud and abuse. For example, the number of Inspector General investigators has remained virtually unchanged during the last 5 years, though the Inspector General's statutory responsibilities, and the size and complexity of the federal programs that the Inspector General investigates has increased significantly. What this means is that in many localities--such as Southern California where the rolling-labs schemes are concentrated--the Inspector General has fewer than two full-time people devoted to health insurance fraud.

Such investigative resource limitations can discourage Medicare claims processors--involving some 80 contractors across the country--from developing cases to refer for further action. That is, the contractors depend on the Inspector General to pursue fraud cases, and when contractors anticipate that few cases will be accepted for further investigation, they have little incentive to develop any but the most egregious cases for referral.

Our work examining how Medicare contractors review complaints they receive alleging fraud illustrates the potential cost of not pursuing these leads. Beneficiary complaints of provider fraud and abuse are Medicare's first line of defense against misspent program dollars. Inadequate investigation of these complaints can result in missed opportunities to recover overpayments and to send a message that fraudulent or abusive behavior will not be tolerated.[2]

In fiscal year 1990, Medicare contractors reported receiving about 18 million calls--most of which were from program beneficiaries. In our review of calls at five contractors,

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[2]Medicare: Improper Handling of Beneficiary Complaints of Provider Fraud and Abuse (GAO/HRD-92-1, Oct. 2, 1991).

however, we found over half of the complaints that involved allegations of fraud or abuse were not referred to contractor investigative staff. Not all complaints that were properly referred, moreover, were adequately investigated.

One of the beneficiary complaints we reviewed involved the sale of durable medical equipment. A physician and a nurse, claiming Medicare had sent them, came to the beneficiary's home. The same day, a supplier delivered several medical equipment items to her home. The beneficiary asked the supplier to pick up the equipment and not bill Medicare for it because she neither ordered nor needed the equipment. She later received a notice, however, that Medicare had paid the physician for a home visit and the supplier for the equipment. At first, the contractor did not investigate to determine if fraud or abuse had occurred but required only that the supplier refund Medicare for its payments, which totaled roughly $700.

Once we alerted the contractor to the case, however, the contractor conducted additional investigations of the supplier and affiliated physicians, uncovering over $450,000 in overpayments by Medicare. The contractor is also investigating a medical supply company operating at the same address but under a different name and Medicare provider number. These are examples of the types of cases that, once documented, would be referred to the Inspector General for further action.

CONCLUDING OBSERVATIONS

Only a fraction of the fraud and abuse committed against the health care system is identified and prosecuted and that which has been detected has involved substantial sums. Without adequate resources, effective investigation and pursuit of health care fraud is not possible. Currently, dishonest providers can continue operating, in part, because of the lack of staff and money dedicated to pursuing them. Today, an essential health care system goal must be to improve insurers' access to legal and punitive remedies to fraud and abuse.

However, added resources alone will not succeed in overcoming fraud and abuse in the health insurance industry. As we discussed in our May 1992 report cited earlier, structural issues such as limitations on information sharing among insurers and incompatible data systems allow unscrupulous providers to move from one insurer to another. The complex issues involved in developing remedies present a dilemma to policymakers: on the one hand, safeguards must be adequate for prevention, detection, and pursuit; on the other, they must not be unduly burdensome or intrusive for policyholders, providers, insurers, and law enforcement officials.

Therefore, as we discussed in our May 1992 report cited earlier, we believe that the Congress should consider establishing a national health care fraud commission composed of private and public payers, providers, and law enforcement agencies. The issues involved entail conflicting legal and administrative objectives that, in our view, would best be resolved by a representative body. That is, such a commission would be best suited to weighing trade-offs: greater information-sharing among insurers vs. concerns over privacy and antitrust issues, greater regulation of provider ownership arrangements vs. concerns about restraint on competition, and--most germane to today's proceedings--investment of resources in health care fraud vs. the devotion of resources to other criminal activities.

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Mr. Chairman, this concludes my testimony. I'd be pleased to answer any questions.